STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 01 B. WING _____	01/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SALEM, THE	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/31/11 Facility Number: 000223 Provider Number: 155330 AIM Number: 100267680 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, The Waters of Salem was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 92 and had a census of 89 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 02/02/11. APPROVED 3/11/11 The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:	K 000	RECEIVED FEB 23 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Cheryl A. Jones — CEO/Administrator for — 2/18/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors was equipped with a positive latch. This deficient practice could affect 57 residents, as well as staff and visitors in the 100, 200, and 300 Halls. Findings include: Based on observation on 01/31/11 at 12:30 p.m. during a tour of the facility with the Maintenance Supervisor, the Communications Room door was not equipped with a positive latch, only a dead bolt latch engaged by a keypad. This was acknowledged by the Maintenance Supervisor at	K 018	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute and admission or agreement by this facility if the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executied in compiance with state and federal laws. **K018 NFPA 101 LIFE SAFETY CODE STANDARD** 1. Corrective action taken: Installed new combination lock device with self locking in order to be in compliance. 2. Residents Identified: There were no residents effected. 3. Measures Taken: The Maint Director will inspect the combination lock device monthly as a part of the monthly preventive maintenance program to ensure it meets set standards. 4. How Monitored: CEO/Designee will monitor the above corrective acitons and will be reviewed in Quarterly QA meeting. **5. This plan of correction constitutes our crdible allegation of compliance with all regulatory requirements. our date of compliance is: 2/11/11.**	

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K 018	Continued From page 2 the time of observation. 3.1-19(b)	K 018		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 10 hazardous area room doors, such as a room over 50 square feet in size containing a large amount of combustible material, was equipped with a self closing device on the door. This deficient practice could affect 57 residents, as well as staff and visitors in the 100, 200, and 300 Halls. Findings include: Based on observation on 01/31/11 at 11:55 a.m. during a tour of the facility with Maintenance Supervisor, the Wound Nurse Office was over fifty square feet in size and filled with full and empty cardboard boxes. The door to this room was not provided with a self closing device. This was acknowledged by the Maintenance	K 029	**K029 NFPA 101 LIFE SAFETY CODE STANDARD** 1. Corrective action taken: Installed self closing device, removed empty cardboard boxes and installed shelfs in order to be compliance. 2. Residents Identified. There were no residents effected. 3. Measures taken: The Maint Director/Designee will inspect the self closing device monthly as part of the monthly preventive maint program to ensure it meets set standards. The DON/Designee will ensure that empty cardboard boxes and other items are in shelfts in order to be in compliance inside Wound Nurse Office. This will be accomplish during monthly QA rounds. 4. How monitored: CEO/Designee will monitor the above corrective actions aAnd will be reviewed in Quarterly QA meeting.	

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K 029	Continued From page 3 Supervisor at the time of observation. 3.1-19(b)	K 029	**5. This plan of correction constitues our credible aAllegation of compliance with all regulatory requirements. Our date of compliance is: 2/11/11.**	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants in the facility.	K 144	**K144 NFPA 101 LIFE SAFETY CODE STANDARD** 1. Corrective action taken: Installed remote shut off device for the generator. This device located in maintenance office. 2. Residents Identified: There were no residents effected. 3. Measures Taken: The Maint Dir/Designee will inspect the remote shut off monthly as a part if tge monthly gernerator preventive maintenance program To ensure it meets set standards. 4. CEO/Designee will monitor the above corrective actions and will be reviewed in quarterly QA meeting.	

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K 144	Continued From page 4 Findings include: Based on observation of generator equipment on 01/31/11 at 10:00 a.m. during a tour of the facility with the Maintenance Supervisor, no evidence of a remote shut off device was found for the generator, furthermore, during observation of the generator it was indicated the generator was powered with less than 100 horsepower, however, the Maintenance Supervisor indicated the generator was installed new in 2007. Finally, based on interview at 12:15 p.m. on 01/31/11, the Maintenance Supervisor indicated there was no remote shut off device for the generator. 3.1-19(b)	K 144	**5. This plan of correction constitues our credible allegation of compliance with all regulatory requirements. Our date of completion: 2/11/11.**	